UTAH DIGITAL HEALTH SERVICE COMMISSION MEETING

Thursday March 3, 2022, 10:00 AM – 12:00 PM MT
Room 125 (Cannon Building) & Google Meet (meet.google.com/wwk-nixj-mkd)

Minutes

Members Present: Matthew McCullough, Brian Chin, Chris Klomp, Dallas Moore, David Cook, Franklin Peters, John Berneike, Rand Rupper, Seraphine Kapsandoy-Jones, Trish Henrie-Barrus, Todd Bailey

Additional Attendees: Kyle Lunt, Heather Borski, Deepthi Rajeev, Huaizhong Pan, Jason Barnes, Keegan McCaffrey, Leisha Nolen, Robert Wilson, Valli Chidambaram

Welcome and Motion

The meeting started at 10 o'clock. Navina Forsythe handed the administrative responsibilities to Kyle Lunt for the Digital Health Service Commission (UDHSC) meeting, so he facilitated the meeting from the Department of Health side. Matt McCullough welcomed everyone to the UDHSC meeting. Every attendee gave a brief self-introduction.

Motion to approve November 2021 and January 2022 UDHSC meeting minutes
Rand Rupper made a motion to approve the November 2021 and January 2022 UDHSC meeting minutes. Chris Klomp seconded. All commission members were in favor of approving.

Motion to approve 2021-2025 HIT Strategic Plan
Matthew Mccullough made a motion to approve the 2021-2025 HIT Strategic Plan. Todd Bailey seconded. All commission members were in favor of approving.

Introduce of the new members

Matt welcomed 3 new commission members, Dr. John Berneike, Franklin Peters and Dr. Dorothea Verbrugge. Dorothea Verbrugge could not attend the meeting. John Berneike briefly introduced Dr. Verbrugge. Kyle clarified that Dr. Verbrugge is on the commission as a representative of the health insurance industry. Dr. Bernanke fills the position of a physician involved in digital health service. Franklin Peters fills the position of a healthcare system representative.

Commission Member Spotlight

Seraphine Kapsandoy-Jones Introduced herself. She is a Chief Clinical Information Officer at Intermountain Healthcare with the responsibilities of looking at design and customer experience, focusing mostly on the clinician lens. She also serves as the inaugural Chair for the Equity Steering Committee at Intermountain, and as an Associate Professor at the University of Utah teaching in the Bioinformatics and Nursing Informatics program. Her projects are with women's health, especially in developing countries looking at clinical models, and how to leverage technology for best practices. She also sits on the Multiple Sclerosis Society-Idaho-Nevada-Utah Board of Trustees.

Seraphine gave a brief introduction of Intermountain. The Clinical Informatics and Customer Experience Branch focuses on business solutions, consulting, design and development, adoption and support risk management, data analytics, visualization, and content management. Her team is looking at technology from four different lenses; prioritizing projects; understanding processes and problems to be solved; addressing process and people issues;

and considering technology solutions.

Seraphine said when you look at healthcare in the United States. Healthcare contributes 10% of our health and well-being but it consumes 90% of the $2.6 trillion spent. It is squeezing dollars for education and other areas. So, she comes in with a nursing lens to think about how to maximize the output. She thought there are three areas that have barriers - value-based reimbursement; interoperability & regulations; and funding & rewards. She thought what this commission can help and influence these areas from a state level but a national level.

She saw many parents of wounded children struggling with a lot of what they needed to do when back home from the ED. So, at the Primary Children's hospital, she started a program to do video calls on cell phones so that parents can show the wounded area, so that she could decide if the parents can make some interventions at home. She got really interested in digital health and interested in how they look at outcomes from a nursing perspective. She thought this commission can help look at how to maximize resources in the community to extend practices and help patients while they're at home before they must reach the hospital settings.

Seraphine showed that only 9% of US healthcare spending is on health behaviors. David Cook wondered if there is a way to increase that for the social determinants of health. Seraphine thought the data including where the patients live, what resources are around the patients, food insecurities, and other things will impact the healthcare outcomes. She thought healthcare providers need to invest in looking at bringing digital health to give the whole and holistic approach of what's happening with the patient.

John Berneike also mentioned that mental health is a big part of a patient's overall health condition. He mentioned that UHIN has a GIS-based dashboard, where you can see the patients by zip code and look at different health conditions based on where your patients live.

Trish Henrie-Barrus commented on social determinants and mental health. She said in the last couple of years, mental health problems have really exploded, and how to help is a big problem. Brian Chin asked about the 211 Group in the United Way and if commission members overlap with them. Rand Rupper answered that they had a session right before covid including the 211 Group that was focused on social determinants of health. It will be good for these groups to give some progress to the committee. Kyle said he can try to get someone from the One Utah Community Information Exchange subcommittee to present in the UDHSC May meeting.

Rand talked about how data sharing might work. There are lots of issues brought up around privacy. How they could share across the systems, some of which are medical systems and others are more community systems. That kind of data sharing would be at the heart of what this commission could be trying to influence. He also mentioned how schools could connect to the Social Determinants session. Matt said that they are continuing to work on the school-based integration of healthcare services into the school setting and do school-based telehealth. They have a primary focus on mental health services and helping K-12 students to get support there.

Covid Lessons Learned

Leisha Nolen is the state epidemiologist. Leisha, Jason Barnes and Keegan McCaffrey gave a presentation on their data systems and how it worked during covid.

Leisha said that their coronavirus website (https://coronavirus.utah.gov/case-counts/) is very useful for the community and has been their big messaging information system and it's used by people throughout the community. The website is not just used by our population, but it's used by the media and by all different areas. It has been a big resource for our community throughout the pandemic. All these are results of their data systems to bring things together.

She said that Utah data is recognized as high quality across the country, a national best practice, and examples for other states; It was mentioned in national media as exceptional data; they had 29 publications on the pandemic.

Jason Barnes presented the backside of the data systems. Jason said that their approach to public health data systems has started before the pandemic. Their systems could be automated to facilitate the data collection, integration, dissemination in an effective and consistent way. He talked about some of the systems and the ways that they retrieve data from different sources. The electronic laboratory reporting (ELR) receives reports from clinical, reference laboratories, and clinical providers. During the pandemic they have been working with a lot of non-traditional reporters, like long-term care facilities and mobile testing sites. They also worked with a lot of other states to share data across states for residents that live near the border and received health care in other states. Electronic case reporting (eCR) enables the providers' electronic medical record to generate reports and send them to public health for notification of disease beyond laboratory confirmation. It includes demographic, diagnosis, and treatment information. It reduces the burden on the system and staff.

UDOH uses EpiTrax to receive all the data. EpiTrax was built in Utah and launched in 2017. The system has gained national recognition. It contains information about the case investigations for a wide variety of diseases in the state. It is a platform to conduct contact tracing. EpiTrax also is a central repository for their outbreak management.

They also receive syndromic surveillance (SyS) information. It's de-identified and focused on emergency departments and urgent care centers for sending symptoms and visit information at the primary point of care. They also started working on wastewater surveillance looking for Indications of how disease is spreading.

They have been working on whole genome sequencing over the last few years. The capacity increased during the Covid response. Utah is a regional leader in the whole genome sequencing area now. The Utah Public Health Laboratory provides regional support for other states on how to interpret whole genome sequencing.

They also worked with lots of partners. Their systems link to other systems that facilitate the data transfers and record linkages. All these connections are the results of the Promoting Interoperability Programs or Meaningful Use Programs, which provides incentives for the connection of provider systems to public health systems.

Throughout the pandemic they worked with some private sector groups, such as NOMI, Google, and Apple for exposure notifications that anonymously alerts users. They also worked closely with local and tribal health jurisdictions. All the local and tribal health jurisdictions in the state can use EpiTrax to conduct investigations and do public outreach. They have also worked with a lot of federal groups including APHL, CDC, CSTE and NACCHO, and worked closely with UHIN to get connections to data.

Jason mentioned that the EpiTrax consortium is a group of multiple states and local health departments that use EpiTrax. It was released as an open-source product for those jurisdictions to use and contribute.

Keegan McCaffrey said his group in the Bureau of Epidemiology uses the data from EpiTrax to help direct the response. He talked of the challenges in polling, cleaning, and analyzing all these data sets; interpreting that presenting data in transparent, reproducible, digestible and actionable ways; and in dissemination data to get the right data to the right people at the right time. They like to think of their data systems like a highway where data comes from clinical, syndromic, and wastewater sources that get onto the highway, merge together and are processed. When needed, they can take an off-ramp to the right person at the right time. EpiTrax is their centralized case surveillance system. UHRMS, the hospital reporting system, provides the Covid-19 patients in hospitals. They also pull and analyze data from

different data systems every day to create the data reports and to have a good understanding of where we are in the pandemic and to help the Covid prevention.

They use R to do cleaning and analysis, and display the data to the public dashboard, internal, and local health departments. They also provided a lot of csv files to researchers and other response groups and tried to meet people's need for the pandemic.

Keegan said the same systems are also used to respond to multiple health threats such as flu, RSV, and opioids. Because many Covid-19 tests moved to home, they added non-testing biased measures of the pandemic. The dashboard clearly showed the improvement of the protections of two doses of the vaccine and the booster doses compared with the unvaccinated people.

Leisha Nolen summarized the lessons they learned, which included the importance of good partnerships. They need more data systems for automating processing data and interoperability within and across states. They need to make public trust so that they can act on the recommendations.

For the future, Jason said they will continue the evolution of the systems, centralize the systems and automate the processes. They started cloud migration of the systems. CDC started the Data Modernization Initiative (DMI) effort to put federal funding to support upgrading the systems, processes and interfaces for Covid and other disease responses. They will continue to focus on national data standards including ICD-10 and FHIR standards. They will expand eCR to more facilities and use a state data warehouse and improve data accessibility to local health departments.

Keegan added that they will utilize the tools built for COVID-19 for other conditions and continue to automate these analysis and outbreak identification. They will leverage WGS data more broadly to better understand and respond to the transmission events.

Leisha said that they also want to enhance their systems so that the systems can collection data systematically, disseminate data automatically and reproducibly, and communicate the data in a transparent, interoperable and actionable way.

Regarding how providers or healthcare systems use these data to make decisions. Seraphine said they use this data at Intermountain as part of their daily huddles for their covid management plans and interventions. Leisha also said that their data can support the hospitals and clinics so that they could protect their own people.

Matt thought that they can work with everybody to summarize and make some recommendations to improve the interoperability and the technical infrastructure. Those are the things that this commission can do rather than just talk about them.

Kyle thought that was a great idea and he will coordinate with Dr. Nolen, Keegan, and Jason to figure out how they will coordinate that effort and circle back to Matt and Preston. Brian Chin fully supports the modernization of the technologies.

Update on DHHS Consolidation

Heather Borski is the Deputy Director of the Department of Health. She gave an update on the Department of Health and Human Services consolidation.

Heather said that in the last legislative session, the legislature passed HB365, which set out the merger of the Department of Health and the Department of Human Services. Part of Medicaid will be moving to the Department of Workforce Services focused on Medicaid eligibility quality control. She said the goals of the merger are to more efficiently and effectively manage health and human services programs, align health and human service policies for the state, and promote health and quality of life for the people the Departments serve.

The bill originally passed in March of 2021. They had created a transition plan and submitted before December 1st, 2021. There have been additional tweaks to legislation in this year's legislative session. SB45 is taking the next step to make the merger of the two agencies legally possible. The goal date is July 1st, 2022 for us to be a legally merged Department of Health and Human Services.

Heather said that there are a lot of reasons and a lot of benefits from merging these two agencies. It will allow us to align complementary priorities, for example, human services tends to take a closer look at individual interventions while public health looks at whole communities. We'll benefit from bringing those two complementary perspectives together. It will allow us to better integrate physical and behavioral health services; will promote efficiency, accountability and fiscal responsibility; and will help to improve customer experience and outcomes. It will also allow us to harness program synergies across both agencies. We have common program areas, addressing physical health, behavioral health, prevention, family services, licensing, Medicaid. Single individuals and single families may have multiple touch points within the organizations. The full range of resources available in the two agencies could be beneficial to them. There's a huge overlap in the populations that we serve. In addition, physical health and behavioral health conditions are co-occurring. The consolidation will give us a chance to leverage partnerships through the overlapping programs, overlapping staff, overlapping partnerships, and agreements.

In the two systems, there are over 250 data systems and 90 contracts for IT Services. Consolidation gives us an opportunity to align our data systems and contracts, and streamline and simplify those processes and services to better do our work and better serve our clients. It'll give us an opportunity to coordinate health and human service policies around things like mental health coverage, healthy environments, joint settlement agreements, and so on.

Heather said that over the nine months from March to December, about 300 staff were engaged in various work groups for the consolidation. One of the first things they did together was draft a problem statement and a vision statement. The problem statement says that the current Health and Human Services model and accompanying policies have led to a fragmented system of services, creating unnecessary barriers and challenges to accessing care for those most in need. The systemic challenges contribute to inequities and health outcomes and determinants of health. A consolidated department will reduce these challenges and improve outcomes for all Utahans, particularly those within communities where disparities are greatest. Their vision is that we will advocate for support and serve all individuals and communities in Utah. We will ensure all Utahns have fair and equitable opportunities to live safe and healthy lives. We will achieve this through effective policy and a seamless system of services and programs.

She said they created an organizational chart to strive to best align the programs and services. Tracy Gruber has been named as the executive director of the Combined Department of Health and Human Services. Dr. Michelle Hoffman will be the executive medical director or state health officer. Data systems and evaluation across both organizations are being brought together. One of the long-term goals is a common data warehouse across the entire agency, so that we can track an individual through each of the touch points that they may have services in the combined agency. They did create a transition plan that was delivered to the Governor's office and the legislature on December 1st and people can review that plan in detail at hhsplan.utah.gov. It lays out all the major steps that they were intending to take to bring these two organizations together.

Heather said they were working together to pull together the budget and finances, to work on agency policy, culture, and branding. They were starting to move staff and facilities across the Multi-Agency State Office Building to the Cannon Health Building to best align their staff to do the work needed and to match the organizational structure. They were working to develop performance measures. Results Based Accountability will be the method that is used to

foster common language, common thinking around developing performance measures, and ensuring that systemic throughout the entire organization that they are using similar processes and strategies, and using common language.

They are tracking efficiency costs, programmatic efficiencies, operational efficiencies, and also thinking more broadly about how their customers can be better served through this merger. A fully functioning legal agency will be here by July 1st, 2022, but they recognize that July 1st is really the start of a process, and it will take 3-5 years to recodify and optimize as a fully functioning Department of Health and Human Services.

Matt asked, because there are 250 data systems and 90 contracts for data providers, if there is any way that the Digital Health Service Commission can help support or comment on future collection and dissemination of data and interoperability. Heather said that they were just starting to assess these data systems now and are trying to figure out ways in which we can find efficiencies or streamlining of data systems. Kyle believed that this commission could contribute in the future.

Seraphine loves the idea of the individual to get services from all the different points. She wanted to know at the case management level with healthcare systems, how they connect patients with resources from a data and a digital standpoint.

Kyle said that they have the One Utah Road Map. The Department of Health has piloted a community information exchange. Some ideas are having referral systems between different entities and different services. There are people from different areas on the subcommittee. He may try to ask the subcommittee to present at the UDHSC May meeting. Heather said another example might be chronic diseases. They were trying to figure out how they can better partner with the healthcare system to get the de-identified data and help to understand the community context and environments of their patients.

Wrap Up

Matt adjourned the meeting at 11:56